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The Surgical management of suppurative forms of tubal and ovarian disease.

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THE SURGICAL MANAGEMENT OF SUPPURATIVE FORMS OF TUBAL AND OVARIAN DISEASE.*

By Joseph Price, M. D., Philadelphia.

For centuries there was no precise knowledge of the character and organs involved in pelvic suppuration. Everything was put under the head of pelvic abscess. The term in itself conveys an idea of the limit of the knowledge of the earlier surgeons—if by such name we may designate them—of the character, the relating functions of the pelvic organs, and the troubles in which they are frequently involved. But it is not to profitable purpose to spend much time in a cemetery; we find more profitable teaching in the work of the men of our own than in the work of the men of the earlier centuries. Limited as was the nomenclature, it served to cover about all that was known.

We are no longer greatly in need of medical and surgical terms. Every experimenter, with the coincidence or accident of a success, takes a cross-field cut to get into print and herald the new method or doctrine his genius has evolved, and not satisfied with anything in the old or in the clearly descriptive and intelligible of the modern, he invents a new nomenclature, and to his new fad or "pad" gives the sweet seductive euphony of his name.

We would naturally suppose that as we grow in precise knowledge of the character and organs involved in pelvic suppuration there would be a more general consensus of opinion as to the structures involved in the most common varieties of intrapelvic disease and as to treatment.

While our literature is burdened with discussions of pelvic diseases and their treatment, there have been a few men doing our scientific thinking for us—a few who have answered many of the obstinate scientific questions which lie within the range of facts related to other facts.

Bernetz and Goupiel have carried the spirit and accuracy of the mathematician into their minute investigation, their keen scrutiny of

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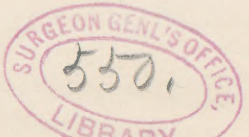

co-ordinate influences and results. They were investigators and not mere controversialists; they devoted time and effort not to disputing about facts, but to discovering them. Our science would be a sterile thing without the impetus, and the patient, prolonged investigation such men give it. What is best, they give us classified facts, vital relations; give us results and reasons for them, give us discoveries and not inventions of doubtful value, the logical conclusions of practical investigators and not mere theorizing. As close observers they have given us the results of their observations. A very distinguished scientist has given us a broader meaning of observation than that of common acceptance. He has defined it to mean "the strenuous exertion of all the faculties behind the eye as well as the assiduous training of the eye itself." He adds: "I have educated five observers; one of them, to be sure, has turned out to be my deadliest personal enemy, but still I affirm that he is a good observer, and that is the best compliment I could pay him were he my dearest friend." It is true that the men who have given us all the science worth the name have not been without their scientific enemies.

The source from which most mischief has come to genuine scientific discovery has been through a class of small critics of the kid-glove or japonica variety—those amateur scientists who glean up and combine all the discoveries and results of the experience and observation of many specialists into one confused mixture. They have been obstructionists for the reason that they have diverted attention from subjects of vital importance and which should receive the most profound study. It is not claimed that all the conclusions of our eminent scientists are without the circuit of legitimate criticism and controversy. There are many errors to be corrected. We have not outgrown the possibility of new achievements. There is much yet within the chaos of facts for our finding.

There are, however, in our science and art some settled truths—truths settled by clinical and surgical experience, which we can not do better than adhere to; the successes are not the same when they are deviated from for the new of some adventurer. Early in the history of true pelvic pathology and surgery these adventurers and obstructionists referred to denied the existence of tubal and ovarian disease. Later, recognizing the error of their ways, they again became obstructionists in the surgical management. Still later they became advanced thinkers and originators—full of deep surgical wisdom; critics of well-established, safe, and simple forms of treatment. To follow the campaign of a few would-be leaders is one of the most

interesting and at the same time disgusting chapters in pelvic pathology and surgery. First, they denied the existence of tubal and ovarian disease, occlusion of tubes, with retention of blood, pus, and water, with partial or general adhesions to important viscera or structures. Later they admitted all, but they had tortured original methods of treatment.

Simple, direct, and positive methods were criticised. A few months or a year later they tried to startle the world by rather ultra and heroic methods of treatment, modifying or changing their views and methods about twice yearly, fully contradicting themselves about every six months. Nothing could be more unfortunate for the numerous sufferers throughout the world than the present disagreement as to real pathological conditions demanding simple surgery. Recently the whole subject has been greatly complicated by new methods, new appliances, and positively new men or operators. I say new operators because they have been in the field but about two years. Mr. Tait organized a large and wonderful school in pelvic surgery. They followed his simple and complete methods with startling success throughout the world. The reports of small and large series of successful operations for greatly complicated troubles, were very numerous. The reports in about all cases were of a pleasing nature.

Early in the history of this great work the followers of Mr. Tait had a lower mortality and better results in a more complicated class of troubles to deal with than the present school of undecided operators.

Much of the new work is that of a class of men who have served a very short apprenticeship. The new gynæcologist, like in homœopathy—that which is new is not true, that which is true is not new, a fact peculiar to both. The noble battles fought out are worthy of our thoughtful consideration. The statistics and tables given will not stand before the veteran abdominal operator. Much of the work shows decided timidity, and some of the tables, with the history of the cases, would indicate unjustifiable work Some of the blind and blundering procedures remind one of a very common expression of women —an untruth in its bearing—"What you don't know will never hurt you!" It is by what we have done and are doing, and the results thereof, that professional and non-professional judgment is influenced. Electricity, sacral resections, and a number of fads, are no longer heard of; they served but a short day. Infrapubic work, so much lauded at present, will do a world of mischief before it is discarded. I can

not understand how any one familiar with pelvic disease, with knowledge based upon a large suprapubic experience, can claim superiority for the lower method. With a large experience with vaginal hysterectomy for malignancy, and in operative obstetrics, the facts, as confirmed by experience, force one to the adoption of the upper method for ease, for the exercise of good surgical judgment, and completion and refinement of technique. Sufficient time has not elapsed to give statistics value as a criterion of judgment. A longer and more general trial of the method will give shocking results. For actual disease—pelvic, acute, or chronic—the numerous unrecognized injuries and accidents to surrounding structures and important viscera will stay the hand of all conscientious surgeons or bring reproach upon abdominal surgery generally. The absolute incompleteness of this method must condemn it. An operation, to be complete, must remove all that it professes to remove. It must correct all pathological complications and lesions, and leave all surrounding structures in as normal relations as possible.

Unrecognized and unrepaired fistula to the number of five or six per cent. following the infrapubic operation is alone sufficient reason for its total rejection as one of the most imperfect, inefficient, and unsatisfactory methods ever practiced in gynæcology.

The careful reading and studying of good abdominal and pelvic literature—the contributions of experienced investigators and thoughtful observers of all phases of the operation—furnish the most convincing arguments in favor of the suprapubic method. Ignorance, prejudice, or timidity only will bar out the proofs so ready at hand. The logic of results certainly will not. The common expression "inoperable" comes from the infrapubic operators or adventurers who have just *stumbled* into the field of abdominal surgery, and are asking, in the phrase of an ex-Congressman, "Where am I at?" He attempts an abdominal section, finds a few adhesions, wipes his thoughtful brow, breathes out a few expressions of surgical wisdom, closes an eighteen-inch incision by "My method"—his certainly—and then declares the case "inoperable."

He then suggests or attempts the new dismal-swamp procedure by stabbing through the vaginal vault with a knife or scissors, a pus-tube, or ovarian abscess, or extirpates the little healthy uterus, stating that "the adhesions of the appendages were so solid that I could not complete their extirpation." I presume this same operator and authority would remove the penis for unilateral or bilateral buboes, and consider it good surgery. The suprapubic surgical management of sup-

purative forms of tubal and ovarian disease is easy in the acute cases, complicated and trying in the many neglected and chronic cases, but rarely is it necessary to "back out from the operation at the table" or abandon the operation at any point. The management of the omental bowel, small and large adhesions, careful repair of all bowel lesions, is easy and vital in every case.

The enucleations are complete and easy in puriform disease. A prominent operator records that "I have left twenty-one times parts of the appendages in the pelvis in the one hundred and fifty-seven cases of serious suppuration upon which I have operated."

Now a moment's reflection upon this recorded admission of a man traveling in America as a gynæcological missionary, where gynæcology had its genesis. I have hundreds of times repaired bowel lesions, and have freed adhesions by the hour. Nothing in my professional work gives me more pleasure than our ability to deal with visceral complications and lesions incident to the natural history of intra-abdominal and pelvic disease. The scientific and surgical interest of the American profession in bowel and all visceral surgery, as exhibited in the records of surgeons, is a matter of very natural and just pride. There will be no more encouraging or brighter chapter in the history of surgery than that which will record the work of the last decade.

The suprapubic method, as perfectly practiced—free of errors of omission and commission—is the only operation that can give perfect, immediate, and permanent results. The accidents, complications, and sequelæ commonly referred to in discussions of the suprapubic operation—that of infection, adhesions, fistula following drainage, and improper ligatures—are all avoidable, except in very rare, very feeble patients.